TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UMC Physician Network

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-0334-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I sent a request for reconsideration for all dates quoting TX DWC Rule 180.28 and a portion of the rule "a peer review cannot be a review for all future treatment." Sedgwick processed the reconsideration and continued to deny the dates upholding the original decision.

Amount in Dispute: $390.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on October 17, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2016 July 1, 2016 July 2, 2016	99213 99213 99213, 99080-73	$390.00	$348.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §182.28 sets out the requirements for peer review.
4. 28 Texas Administrative Code §129.5 sets out the reimbursement for work status reports.
5. 28 Texas Administrative Code §137.100 sets out treatment guidelines.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 5264 – Payment is denied-service not authorized
   - W3 – Additional payment made on appeal/reconsideration
   - 216 – Based on the findings of a review organization
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 6284 – Payment is denied-service not authorized
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - 247 – A payment or denial has already been recommended for this service

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Was prior authorization required?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for $390.00 for professional medical services on dates of service May 18, 2016, July 1, 2016 and July 2, 2016.

   The insurance carrier denied disputed services with claim adjustment reason code 216 – "Based on the findings of a review organization."

   Review of the submitted documentation finds a "Peer Review" with a date of May 11, 2016. No documentation was found to support a review of an IRO (Independent Review Organization) as defined in 28 Chapter 12, Part 1, Subchapter A, Rule §12.5 which states in pertinent part,

   > (20) Independent review organization or IRO--An entity that is granted a certificate of registration by the commissioner to conduct independent reviews under the authority of Insurance Code Chapter 4202. An IRO must have the capacity for independent review of all specialty classifications and subspecialties contained in the two-tiered structure of specialty classifications set out in §12.402 of this chapter.

   28 Texas Administrative Code §137.100 (e) and (g) state,

   > (e) An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.
   >
   > (g) The Insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

   Review of the submitted documentation finds insufficient evidence to support a retrospective review compliant with Rule 137.100(e) was performed as stated above the "Peer Review" was dated May 11, 2016. The dates of service in dispute are May 28, 2016, July 1, 2016 and July 2, 2016 which are after the submitted review was performed. The carrier's denial is not supported and will not be considered in this review.

2. The carrier also denied the services in dispute as 197 – "Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code §134.600 (p) states,

Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all work hardening or work conditioning services requested by:

(A) non-exempted work hardening or work conditioning programs; or

(B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury; or

(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

Review of the narrative description of the submitted codes finds the following:

- 99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

- 99080, 73 - Special reports such as insurance forms

These services are not found within the above stated rule as requiring prior authorization. Therefore, the carrier's denial for prior authorization is not supported.

The services in dispute will be reviewed per applicable rules and fee guidelines below.

3. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.)

The maximum allowable reimbursement for the professional services is calculated as follows:

- Procedure code 99213, service date May 18, 2016. The MAR is calculated as (DWC Conversion Factor/Medicare conversion factor) x $70.06 or (56.82/35.8043) x $70.06 = $111.18
- Procedure code 99213, service date July 1, 2016. The MAR is calculated as (DWC Conversion Factor/Medicare conversion factor) x $70.06 or (56.82/35.8043) x $70.06 = $111.18
- Procedure code 99213, service date July 2, 2016. The MAR is calculated as (DWC Conversion Factor/Medicare conversion factor) x $70.06 or (56.82/35.8043) x $70.06 = $111.18

The remaining service in dispute is 99080 -73. The applicable rule is 28 Texas Administrative Code 129.5(i) which states in pertinent part,

Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15.

The Division finds the requestor is due $15.00 for the submitted report.

4. The total allowable reimbursement for the services in dispute is $348.54. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $348.54. This amount is recommended.

   Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $348.54.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $348.54, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	November 17, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.